[REAL] HEALTH SOLUTIONS
at
ribley family chiropractic

PROVIDER

Which Doctor are you seeing today?
☒ Dr. Ken Kilgore

Welcome

ENTRANCE DATA

Name:____ Date of Birth: ___________________________ Age: __________
(full name, please do not use initials) (month/day/year)

Address:____ City: ______________________________ Zip:_____________

Home Phone: ________________________ Work Phone: _____________________ Cell Phone: _______________________

Email: ____

How did you hear about us? ______________________________ Have you seen a chiropractor before? ______________

Marital Status: ☐ Married __________________________
Spouse's Name
☐ Single
☐ Divorced
☐ Widowed

Payment in full is expected at time of service unless prior arrangements have been made.

Number of Children: ____________ Ages: _________________

Your Employer: ______________________________________ Occupation: ______________________________________

Who is responsible for your bill? ☐ Self ☐ Spouse ☐ Medicare ☐ Health Insurance ☐ Auto Insurance

Do you have health insurance? ☐ Yes ☐ No Insurance Company: _______________________________________

Primary's Name: ______________________________ Date of Birth: __________________ SS#: _______________________

Do not write below this line.

Healthcare Authorization and Privacy Policy

I have been provided with a copy of the Notice of Privacy Practices for Protected Health Information. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (PHI) that will occur in my treatment, payment of my bills or in the performance of health care operations of this chiropractic office. A copy of our notice is attached and we encourage you to read it and request your own copy if you would like one.

This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information. I hereby give permission to Ribley Family Chiropractic (RFC) to use and/or disclose Protected Health Information in accordance with the following:

SPECIFIC AUTHORIZATIONS:

- I give permission to RFC to use my address, phone number, and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about treatment alternatives, or other health related information.
- If RFC contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.
- I give permission to RFC to use my name on a welcome board, referral board, and birthday board.
- I give permission to RFC to use my photograph on their patient picture bulletin board and other marketing materials, such as their brochure, website, and ads in print media.
- I give permission to RFC to use any testimonial written by me for marketing purposes, such as sharing with other patients or potential patients, in their brochure, on their website, or in ads in print media.
- I give RFC permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with doctor at any time in private the doctor will provide a room for these conversations.
- By signing this form I am giving RFC permission to use and disclose my protected health information in accordance with the directives listed above.

The use of this format is intended to make my experience with RFC's office more efficient and productive, as well as to enhance my access to quality health care and health information. This authorization will remain in effect for the duration of my care at Ribley Family Chiropractic, plus 7 years or until revoked by me.

Right to Revoke Authorization

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization. You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of RFC. The written notice must contain the following information: Your name, Social Security number, and date of birth; a clear statement of your intent to revoke this AUTHORIZATION; the date of your request; and your signature. The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by RFC for its own use/disclosure of PHI. *(Minimum necessary standards apply.)*

I have the right to refuse to sign this AUTHORIZATION. If I refuse to sign this AUTHORIZATION, RFC will not refuse to provide treatment however, it will not be possible for RFC to file third party billing on my behalf and I will be responsible for 1) payment in full at the time services are provided to me 2) scheduling my own appointments since RFC will be unable to contact me 3) all contact with RFC regarding my care. *Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.*

I have the right to inspect or copy, within boundaries, the protected health information to be used/disclosed. A reasonable fee for copying will apply. A copy of the signed authorization will be provided to me.

I have read and understand this Healthcare Authorization Form, the Right to Revoke Authorization Form and acknowledge receipt of The Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

Social Security Number: XXX-XX-______	Date of birth:
Patient Name: (please print)	
Patient's signature (or parent/guardian):	Date:
Name of personal representative *(if applicable)*	
Description of representative's authority to act on patient's behalf:	
Representative's Signature:	Date: